STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155656	A. BUILDING 01 B. WING	05/06/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANTERBURY NURSING AND REHABILITATION CENTER	2827 NORTHGATE BLVD FORT WAYNE, IN46835

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K0000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 05/06/11 Facility Number: 000275 Provider Number: 155656 AIM Number: 100290930 Surveyor: Mark Caraher, Life Safety Code Specialist At this Life Safety Code survey, Canterbury Nursing and Rehabilitation Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility with an attached two story Assisted Living wing was determined to be of Type V (000) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and all	K0000	Submission of this Plan of Correction does not constitute an admission by this facility of any fact or conclusion set forth in the statement of deficiency. This plan of correction is being submitted as required by law. We respectfully request this plan of correction as our allegation of compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	areas not separated from the corridor. Battery operated smoke detection is in all resident rooms. The facility has a capacity of 120 and had a census of 112 at the time of this visit. Quality Review by Robert Booher, REHS, Life Safety Code Specialist-Medical Surveyor on 05/11/11. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			
K0034 SS=E	Stairways and smokeproof towers used as exits are in accordance with 7.2. 19.2.2.3, 19.2.2.4 Based on observation and interview, the facility failed to ensure 1 of 2 stairway enclosure doors were in accordance with 7.2. LSC Section 7.2.1.5.4 requires a latch or other fastening device to be provided. This deficient practice affects occupants within the vicinity of the Assisted Living 500 Hall first floor stairwell door. Findings include: Based on observation with the Maintenance Assistant during a tour of the	K0034	It is the practice of this facility to ensure that stairways and smoke proof towers used as exits are in accordance with state regulations. (1) Corrective action taken for alleged deficient practice: AL stairwell door repaired to latch into the door frame and is equipped with a latching mechanism. (2)Identification of other areas potentially affected by alleged deficient practice: Doors throughout building have been assessed to ensure that they latch into door frame and are equipped with latching mechanism. (3)Measures in place	06/06/2011

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	facility from 12:20 p.m. to 2:20 p.m. on 05/06/11, the Assisted Living 500 Hall first floor stairwell door did not latch into the door frame and was not equipped with a latching mechanism. Based on interview at the time of observation, the Maintenance Assistant stated Health Care residents in the facility are allowed to enter the Assisted Living portion of the facility and acknowledged the 500 Hall first floor stairwell door was not provided with a latching mechanism. 3.1-19(b)		to ensure that alleged deficient practice does not recur: Maintenance director will conduct routine checks during maintenance rounds to ensure that doors are latching as required. Any doors found to have issues will be addressed and corrected. (4) How measures will be monitored to ensure that alleged deficient practice does not recur: Maintenance Director will document door checks on maintenance round log and will report to administrator any issues that are identified. Administrator will review doors for latching correctly during wkly rounds and will discuss findings with maintenance director as needed. Maintenance rounds Log will be reviewed monthly by the CQI committee for 3 months and then once a quarter thereafter. Trends of non-compliance will be addressed and corrected.	
K0038 SS=E	Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 Based on observation and interview, the facility failed to ensure the means of egress through 5 of 7 exits were readily accessible for residents without a clinical diagnosis requiring specialized security measures. LSC 19.2.2.2.4 requires doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. Exception No. 1 requires	K0038	It is the practice of this facility to ensure that exit access is arranged so that exits are readily accessible at all times in accordance with state regulations. (1) Corrective action to correct alleged deficient practice: Access code has been posted at doors that are equipped with a key pad. (2) Identification of other potential areas that have potential to be affected by alleged deficient practice: Maintenance	06/06/2011

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	door locking arrangements without delayed egress shall be permitted in health care occupancies, or portions of health care occupancies, where the clinical needs of the residents require specialized security measures for their safety, provided that staff can readily unlock such doors at all times. This deficient practice affects residents, staff and visitors needing to exit the building from the Front Entrance, 100 Hall Foyer, 400 Hall exit, Rehab exit and the 500 Hall exit. Findings include: Based on observation with the Maintenance Assistant during a tour of the facility from 12:20 p.m. to 2:20 p.m. on 05/06/11, the Front Entrance, 100 Hall Foyer, 400 Hall exit, Rehab exit and the 500 Hall exit doors were magnetically locked and could be opened by entering a four digit code, but the code was not posted. Based on interview with the Administrator during the exit conference at 2:20 p.m. on 05/06/11, only residents in the 300 Hall have a clinical diagnosis to be in a secure building and a resident without the clinical diagnosis in the other portions of the facility would have to ask a staff member to let them out if they did not know the code.		Director conducted facility rounds to identify doors with key pad used for access. (3) Measures in place to ensure that alleged deficient practice does not recur: Maintenance Director will examine doors during routine maintenance rounds to ensure that codes are posted and accessible. (4) How corrective measures will be monitored: Maintenance Director will document rounds on maintenance log. Administrator will be review wkly. Maintenance log will be discussed at CQI monthly for 3 months and then quarterly, thereafter.	

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	3.1-19(b)			
K0050 SS=F	Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 Based on record review and interview, the facility failed to ensure fire drills were conducted quarterly on the first, second and third shift for 1 of 4 quarters. This deficient practice affects all occupants in the facility including residents, staff and visitors. Findings include: Based on review of "Emergency Fire/Evacuation Drill" documentation with the Administrator and the Maintenance Assistant from 10:45 a.m. to 12:20 p.m. on 05/06/11, there is no documentation of fire drills being conducted on the first, second, and third shift in the third quarter in 2010. Based on interview at the time of record review, the Administrator stated fire drills were conducted in the third quarter of 2010 but acknowledged there is no documentation	K0050	It is the practice of this facility to hold fire drills as required by state regulations. (1) Corrective Action: Fire drills have been conducted as required by state guidelines and are current. (2) Identification: Monthly documentation records reviewed and found to be current with required documentation. (3) Measures taken to ensure that alleged deficient practice does not recur: Maintenance Director will maintain a binder in addition to the facility's TELS program that will have all fire drill information available. (4) Monitor of system: Maintenance director will provide monthly fire drill documentation to the administrator who will review for compliance. Fire drill reports will be discussed in the CQI committee monthly for 3 months and the quarterly thereafter. Any trends of non-compliance will be addressed and corrected.	06/06/2011

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	of third quarter fire drills available for review. 3.1-19(b)			
K0069 SS=E	Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 Based on observation and interview, the facility failed to ensure 1 of 1 kitchen exhaust system baffles was installed correctly. NFPA 96, 1998 Edition, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, 3-2.5 states filters shall be installed at an angle not less than 45 degrees from the horizontal. This deficient practice could affect any resident, staff or visitor in the vicinity of the kitchen. Findings include: Based on observation with the Maintenance Assistant during a tour of the facility from 12:20 p.m. to 2:20 p.m. on 05/06/11, five of five baffles in the kitchen range hood are aligned horizontally in the kitchen range hood exhaust system. Based on interview at the time of observation, the Maintenance Assistant acknowledged five baffles in the	K0069	It is the practice of this facility to ensure that cooking facilities are protected within facility guidelines. (1) Corrective action: Current baffles have been replaced with new ones that are aligned vertically verses horizontally. (2) Identification of other potential areas that could be affected by alleged deficient practice: Facility rounds indicated there is no other equipment that requires use of baffles on premises. (3) System change to ensure alleged deficient practice does not recur: A preventative maintenance program in place to check baffles wkly after cleanings to ensure they are appropriately installed. Maintenance Director will inservice staff on proper installation. (4) Monitoring system to ensure that alleged deficient practice does not recur: Maintenance Director will check baffles during routine dietary rounds and will document findings. Administrator will review pm log on wkly basis to ensure compliance. Results of the PM log will be reviewed by the CQI	06/06/2011

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	kitchen range exhaust hood are aligned horizontally. 3.1-19(b)		committee on a monthly basis for 3 months and then one month a quarter thereafter. Any non-compliance identified will be addressed as needed through re-education.	
K0144 SS=F	Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. Based on record review and interview, the facility failed to document the load percentage for the monthly load test for the generator for 3 of 12 months. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of generators serving the emergency electrical system to be in accordance with NFPA 110. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: a. Under operating temperature conditions or at not less than 30 percent of the EPS (Emergency Power Supply) nameplate rating. b. Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer. The date and time of day for required testing shall be decided by the owner,	K0144	It is the practice of this facility to ensure that generators are inspected wkly and exercised under load for 30 minutes in accordance with state regulations. (1) Corrective Action for alleged deficient practice: Generator load test have been ran wkly as required and documentation shows load capacity running at 40%. (2) Identification of other potential areas to be affected by alleged deficient practice: Facility rounds completed by Maintenance Director did not find any other equipment that is affected. (3) System change to ensure that alleged deficient practice does not recur: Maintenance staff was inserviced on proper way to figure load capacity of generator when running wkly test. (4) Monitoring of system to ensure that alleged deficient practice does not recur: Maintenance director will document load capacity on preventative maintenance form.	06/06/2011

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	based on facility operations. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of "Direct Supply TELS Generator" documentation with the Maintenance Assistant from 10:45 a.m. to 12:20 p.m. on 05/06/11, monthly generator load testing documented on 02/28/11, 03/28/11 and 04/25/11 show the emergency generator ran for at least thirty minutes during each documented load test but the minimum exhaust gas temperature was not recorded and the percentage of load capacity for 02/28/11 and 04/25/11 was listed as 100% and "FULL" for 03/28/11. Based on interview at the time of record review, the Maintenance Assistant stated the facility did not determine the percentage of load capacity on each of the stated load test dates and acknowledged the percent of load capacity was not 100% or FULL during each of the stated load test dates. 3.1-19(b)		Administrator will review wkly generator records for compliance. Generator PM log will be reviewed at CQI monthly for 3 months and then once a quarter thereafter. Any trends will be addressed as needed.	